BOXING/ KICKBOXING/ MIXED MARTIAL ARTS
PARTICIPANT MEDICAL HISTORY

Florida Athletic Commission
2601 Blair Stone Rd.
Tallahassee, FL 32399-1016
850-488-8500

Legal Name:_____ Federal/National ID#:_____
Last First Middle

Address:_____
Street City State Country

Telephone:_____ E-mail:_____ Date of Birth:_____/_____/_____

Sex: □ M □ F Emergency Contact:_____ Emergency Telephone:_____

This section is to be completed by the athlete.

Health History

Do you have or have you ever had any of the following?

	Yes	No		Yes	No
Seizure	□	□	High blood pressure	□	□
Headaches	□	□	Asthma or wheezing	□	□
Cerebral hemorrhage	□	□	Broken bones or sprains	□	□
Passed out during exercise	□	□	Neck or spine injury	□	□
Double or blurred vision	□	□	Hernia	□	□
Lasik, PRK, or other eye surgery	□	□	Cold sores, fever blisters or herpes	□	□
Retinal Detachment	□	□	Diabetes	□	□
Hearing difficulty	□	□	Bleeding problems	□	□
Broken nose	□	□	Hepatitis	□	□
Chest pain	□	□	Heat stroke/heat exhaustion	□	□
Irregular heart beat or murmur	□	□	Recent illness or fever	□	□

	Yes	No
Have you ever had a concussion, a head injury, or lost consciousness?	□	□
Are you currently using or have you ever used anabolic steroids?	□	□
Have you ever had any surgeries?	□	□
Do any diseases run in your family?	□	□
Have you seen a doctor for *any* medical problem in the last 3 months?	□	□
Do you have any other medical conditions?	□	□
Women only: Have you ever had any type of breast surgery?	□	□
Is there any chance you may be pregnant?	□	□

If "Yes" to any of the above, explain: _____

Are you allergic to any medications or supplements? _____

What medications or supplements are you taking on a regular basis? _____

What medications or supplements have you taken within the last two weeks? _____

Sport History

Amateur Record:_____ Pro Record:_____

Date of last bout:_____ Result:_____ Number of times knocked out:_____

Number of times knocked out in past year:_____ Date of last knock out:_____

I hereby authorize the Athletic Commission to have immediate and unlimited access to any and all medical records which may relate to my fitness to participate in boxing/mixed martial arts or are related to an injury or suspected injury sustained as a result of a boxing/mixed martial arts match. I certify that I have been training faithfully and am in good physical condition. I attest that the answers given above are true and correct to the best of my knowledge and belief. I understand that the examining physician depends on the reliability of the statements I made above and I am not withholding any information from the examining physician. I further understand that all statements and information supplied by me are made under the penalty of perjury and if untrue and not informative, will lead to penalty and/or suspension.

_____ _____ _____
Name (printed) Signature Date

The reverse side of this form is to be completed by the physician.

BOXING/ KICKBOXING/ MIXED MARTIAL ARTS
PHYSICIAN'S PRE-BOUT EVALUATION

Florida Athletic Commission
2601 Blair Stone Rd.
Tallahassee, FL 32399-1016
850-488-8500

Legal Name: _____ Date:_____
Last First Middle

Federal/National ID#:_____ Annual Medical & Eye Exam Complete: Y N

Temp:_____ □ Afebrile RR:_____ BP:_____/_____ HR:_____ SaO2: _____%

	Normal	Abnl		Normal	Abnl		Normal	Abnl
Head/Periorbital/CN's	□	□	Heart (Rhythm/sounds)	□	□	Alertness/Orientation	□	□
PERRLA/EOMI/Vision	□	□	Lungs/Ribs	□	□	Tandem Gait	□	□
Jaw/Oropharynx/Teeth	□	□	Abdomen	□	□	Romberg/Pronator Drift	□	□
Nose (stability/obstruction)	□	□	Upper Extremities	□	□	Finger to Nose	□	□
Ears/Hearing (grossly)	□	□	Lower Extremities	□	□	Motor	□	□
Neck	□	□	Skin (Rashes, infxns)	□	□	Other:_____		

(Women only) Pregnancy: □ Yes □ No

Abnormalities:_____
I hereby certify that based on the statements made by the participant to me and on the Medical History form, and my physical findings, it is my opinion that said participant □ **IS** □ **IS NOT** in good physical condition and able to compete in professional boxing/kickboxing/mixed martial arts.

Reason not cleared for competition:_____

_____ _____ _____ _____
Physician's Name, M.D. Signature License No. Date

PHYSICIAN'S POST-BOUT EVALUATION

□ Won □ Lost □ KO □ TKO □ Decision □ Draw □ DQ □ NC □ LOC □ Choke □Submission Suspension:_____

Time of initial evaluation:_____ Fighter stable: □ Yes □ No

(No entry indicates grossly normal findings.)

	Normal	Abnl		Normal	Abnl		Normal	Abnl
Head/Periorbital	□	□	Extremities(fractures)	□	□	Alertness/Orientation	□	□
Nose (stability/epistaxis)	□	□	Skin (Lacerations)	□	□	HR	_____	
Neck	□	□	Neuro (Grossly)	□	□	SaO2	_____%	
Chest (Grossly)	□	□	Other:_____					

Abnormalities:_____

Mechanism of Injury/Diagnoses:_____

Advised to report for second evaluation in 30 minutes: □ Yes □ No □ Athlete failed to report for second evaluation

Results/time of second evaluation:_____

Recommended Medical Attention:
□ Immediate evaluation in an Emergency Department – Sent to ED at:_____

□ Other:_____

□ Participant refuses advice of physician

Comments:_____

_____ _____ _____ _____
Physician's Name, M.D. Signature License No. Date

I certify that I have given the Ring Doctor true and accurate information. I understand that boxing/kickboxing/mixed martial arts is a potentially dangerous sport that can result in injuries, including but not limited to brain damage, paralysis, and death. I also agree to allow the doctor to treat me for injuries that occur during the event.

Participant's Signature:_____ Date _____